

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON**PREMIUMS IMPOSED ON FAMILIES RECEIVING EXTENDED BENEFITS
DURING A SECOND SIX-MONTH PERIOD**

- A. The following method is used to determine the premium imposed during each premium payment period on families receiving extended benefits (Transitional Medicaid or TMA) during the second six-month period under section 1902(a)(52) and section 1925 of the Act:

The premium amount for months seven, eight, and nine are based on the family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative during months one, two and three. The premium amount for months ten, eleven, and twelve are based on the family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative average income less work-related child cares during months four, five, and six.

The family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative is divided by three and multiplied by one percent. This amount is rounded down to the nearest whole dollar for the per person/per month premium. In no case may the amount of the premium exceed three percent of the family's average gross monthly earnings less the average monthly cost of child care that is necessary for the employment of the caretaker relative.

A family whose average gross monthly earnings less work-related child care is equal to or less than one hundred percent of the federal poverty level (FPL) is exempt from the premium requirement. In addition, pregnant women and children are exempt from the premium requirement.

- B. A description of the billing method used is as follows (include due date for premium payment and notification of the consequences of nonpayment):

Billing is approximately the fifth of each month for the following month of service. If payment is not received by the end of the month of service, the department reviews individual members of the family to determine if they are eligible for another medical

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B. Billing description (con't)

program. If a client is not eligible for another program, the receipt of medical will end the end of the month following the month of service for which the client has not paid the premium. The client is given a minimum of ten days advance notice.

C. The criteria for determining good cause for failure to pay such premium on a timely basis are described below:

Reasons for good cause include, but are not limited to:

1. Illness, mental impairment, injury, trauma, or stress;
2. Lack of understanding the premium payment requirement due to a language barrier;
3. Transportation problems;
4. The client did not pay the premium because they expected to be able to meet the family medical needs, but could not; or
5. The client was given incorrect information or did not receive advance and adequate notice about the premium payment requirements.